Behavioral Health Services Organization (BHSO) - New Provider Type Information in Questions & Answers (Q&A) Format

August 11, 2014

This document is a collaborative product of the Department for Behavioral Health and Developmental and Intellectual Disabilities (DBHDID), Department for Medicaid Services (DMS) and Office of Inspector General (OIG). Many of these questions came as a result of the BHSO webinar held on July 21, 2014. It is advised that you review the recorded BHSO webinar for an informed understanding of BHSO at: http://dbhdid.ky.gov/dbh/bhso.aspx.

Resource: DBHDID BHSO Web Page

General information on the process on becoming a BHSO provider is available on the DBHDID website: http://dbhdid.ky.gov/dbh/bhso.aspx. It is advised that you read information on this web page and listen to the BHSO recorded webinar for an informed understanding of BHSO. This will assist in answering questions you may have that are not provided in this Q&A. Also available on the website are:

- ✓ Recorded BHSO webinar that clearly covers provider type application and licensure process by staffs of the Office of the Inspector and Department for Medicaid Services
- ✓ Power Points used in the BHSO webinar
- ✓ Regulations related to BHSO

BHSO Questions and Answers

Timeframe for Application Licensure and Application Process

At this time, do the OIG and/or DMS anticipate that there will be a cutoff date for gaining licensure and/or Medicaid number as a BHSO?
No—there is no anticipated cutoff date.

We have recently heard that the OIG will review for Alcohol & Other Drug Entity (AODE) and BHSO during the same survey. Is this correct?
*If an entity **is not currently licensed** and submits an application for initial licensure as both an AODE and a BHSO at the same time, the initial AODE and BHSO survey will be combined.*

*If the entity applying for licensure as a BHSO **is currently licensed** as an AODE, the initial BHSO survey will focus on verifying compliance with the standards established in the BHSO licensure regulation. However, if the surveyor observes significant non-compliance with the AODE regulation during the initial BHSO survey, the OIG will investigate further. Additionally, after the initial BHSO survey, subsequent annual surveys may verify compliance with the BHSO and AODE regulations during the same survey to maximize OIG staff resources.*

Are there additional fees for each office besides the OIG license fee of $750.00?
Initial and Annual Fee: *The initial fee for licensure as a BHSO or Residential Crisis Stabilization (RCSU) unit is $750 initially and $500 annually thereafter.*

Fee for Extensions: *A BHSO may provide services at an extension location separate from its permanent facility. A fee of $250 will be charged for each extension site.*

RCSU: *Each Residential Crisis Stabilization Unit (RCSU) is independently licensed and is therefore not allowed to have extension locations.*

Process for Application to OIG & DMS

Can you clarify the timeline for the application process? Do we have to wait until the regulations are approved in mid-December to start the process? Or can we start now?
Entities may apply for BHSO licensure after August 1, 2014.

Are we required to do both back ground checks upon hire and annually?
Pursuant to 902 KAR 20:430E and 902 KAR 20:440E, a criminal record check is required upon initial hire for all personnel employed directly or by contract. Annual criminal record checks are required on a random sample of at least 25% of the organization's personnel.

When will provider type 03 for Behavioral Health Service Organization (BHSO) be available to file to Medicaid to become a BHSO? Is there another form to use until the BHSO one is available?
The forms and requirements for enrollment as a BHSO are posting on the Medicaid provider enrollment website: http:// www.chfs.ky.gov/dms/provEnr/.

Behavioral Health Services Organization (BHSO) Regulation

Where can I view the BHSO regulations?
Please go to the DBHDID website at: http://dbhdid.ky.gov/dbh/bhso.aspx. There is a section on the BHSO regulations.

Also, please note that the DMS BHSO regulations will be posted soon at: http://www.chfs.ky.gov/dms/ordinary.htm

The licensure regulations, 902 KAR 20:430E and 902 KAR 20:440E, may be downloaded from the OIG's website under "Something New" at: http://chfs.ky.gov/os/oig/

The BHSO regulation specifically states that individuals who are related may not be in outpatient group together. So in small agencies and rural communities where it is very likely for family members to be in services and travel together, should those individuals be seen for a family session instead of being allowed to participate in group with others?
Because "regular" group therapy must be provided in a group setting of "nonrelated individuals", the BHSO licensure regulation defines "nonrelated" as an individual who is not a spouse, significant other, parent or person with custodial control, child, sibling, stepparent, stepchild, step-brother, step-sister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, or grandchild.

So family members should participate in family therapy instead. However, this restriction does not apply to multi-family group therapy. We will be clarifying in amended versions of the BHSO regulations (amended through the public comment process most likely in November) that the restriction does not apply to "multi-family group therapy." Multi-family group therapy is a form of group therapy for multiple families addressing a common issue/problem. We will elaborate on this in amended versions of the regulations.

For dual diagnosis client's living in a residential treatment program and receiving individual, group, family therapy and substance abuse treatment; does the program need a CSU license because it is not out-patient?
There are two types of residential treatment programs:

1) Alcohol & Other Drug Entity (AODE) residential programs which must obtain dual licensure as a BHSO if the facility elects to enroll in Medicaid;
and
2) Residential Crisis Stabilization Units (RCSU) which must be separately licensed under 902 KAR 20:440E to provide crisis stabilization if the entity is not already licensed as a PRTF or CMHC.

The annual trainings listed on page 13 number 3, are they going to be provided by the state that we can send our staff to or is the agency required to provide this training once a year to our staff?
The question references 902 KAR 20:430, Section 4(10)(e)3a-d, which requires BHSOs to have "written policies for the administration and operation of the organization, which shall be available to all personnel and include…an annual training program for staff with may include detection and reporting of abuse, neglect, or exploitation; behavioral management, including de-escalation training; physical management procedures and techniques; and emergency and safety procedures." *(answer continues on next page)*

This section of the BHSO regulation establishes a requirement for BHSOs to have on-going, in-service training annually for its personnel and the regulation further lists topics that the BHSOs may wish cover as part of their annual in-service training. This type of training is not provided by the Cabinet for Health & Family Services.

Behavioral Health Services Organization (BHSO) Regulation Fiscal Related Questions

In order to calculate reimbursement through a Behavioral Health Service Organization, what is the Kentucky specific Medicaid rate schedule?
The fee schedule that the Department for Medicaid Services (DMS) uses on which to base rates for the Medicaid BHSO services that are also covered by Medicare is the Kentucky-specific Medicare Physician Fee Schedule. The Centers for Medicare and Medicaid Services (CMS) publishes Medicare fee schedules including regional/state-specific fee schedules on their website. Here are a couple of links to the CMS websites for fee schedules:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html
http://www.cms.gov/apps/physician-fee-schedule/overview.aspx

How will reimbursement for the services that are not on the Kentucky specific Medicaid rate schedule be calculated and what is the methodology? Has *Centers for Medicare and Medicaid Services (CMS)* approved the methodology?
DMS has created a separate fee schedule – the "BHSO Non-Medicare Services Fee Schedule" – for the BHSO services that are not covered by Medicare. It is "incorporated" (attached) to the BHSO reimbursement regulation (907 KAR 15:025) that DMS filed with the Legislative Research Commission on July 22, 2014 and will be posted on the following DMS website:
http://www.chfs.ky.gov/dms/incorporated.htm

CMS has approved the reimbursements.

How do we bill for the services provided now?
The Medicaid BHSO regulations became effective on July 22, 2014; thus, as soon as any entity obtains a BHSO license from the Office of Inspector General and enrolls with the Medicaid program can bill the Medicaid Program (or managed care organization whose provider network the BHSO has joined) for services provided to Medicaid recipients for any BHSO services rendered (that are listed in the DMS BHSO regulations.)

If providing services to recipients enrolled with a given managed care organization (in whose provider network the BHSO is enrolled), the BHSO must bill the given managed care organization. If providing services to individuals who are not under a managed care organization's umbrella but are under the Medicaid fee-for-service umbrella then the BHSO would bill the Medicaid Program.

The new supervisory requirements will authorize any associate to work under the supervision of any independently licensed behavioral health professional as long as the two; the associate and the supervising professional, are employed by or under contract with the same entity, correct?
"Correct. Note that the supervisory relationship cannot violate the supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision."

Regarding the billing supervisor requirement: can a single supervisor supervise staff with different disciplines of licensure? Specifically, can a LCSW supervise CSWs, LPCA, MFTA, etc.?
Yes, as long as they work for the same BHSO and the supervisory relationship cannot violate the supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.

The notes that need to be signed, who can sign these notes?
The rendering practitioner and if the rendering practitioner is one who must work under supervision, the independently licensed clinician serving as the supervisor must also sign the notes.

Is there a timeframe within which those clinical notes need to be signed by the billing supervisor? for example, can they be reviewed monthly and signed electronically or on paper to indicate review, or does each individual note need to be signed and within a specific timeframe?
DMS/DBHDID are not being overly prescriptive about the supervisor's time frame. It would be acceptable for the supervisor to sign the notes on a monthly basis, but the primary point is that supervisors are culpable/responsible for the services rendered under their supervision so they need to act in a way that enables them to appropriately supervise.

Is there an acceptance of an electronic signature compared to a paper signature? What constitutes an acceptable e-signature for KY Medicaid?
Electronic signature is indeed allowed. Below are the electronic signature requirements from the DMS regulation:
(2) A behavioral health services organization that chooses to use electronic signatures shall:
(a) Develop and implement a written security policy that shall:
1. Be adhered to by each of the behavioral health services organization's employees, officers, agents, or contractors;
2. Identify each electronic signature for which an individual has access; and
3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;
(b) Develop a consent form that shall:
1. Be completed and executed by each individual using an electronic signature;
2. Attest to the signature's authenticity; and
3. Include a statement indicating that the individual has been notified of his responsibility in allowing the use of the electronic signature; and
(c) Provide the department, immediately upon request, with:
1. A copy of the behavioral health services organization's electronic signature policy;
2. The signed consent form; and
3. The original filed signature.

The 48 hour regulation in signing the notes, is that the individual that provided the service or the both the therapist that provided the service and the billing supervisor?
The rendering practitioner must sign within 48 hours, but the supervisor can sign later.

Is tele-medicine/tele-therapy allowed and is it considered equivalent to face-to-face services?
DMS has a separate regulation which establishes services that can be provided via Telehealth/telemedicine. The regulation does not currently include many of the services included in the BHSO scope of services nor does it authorize BHSOs to provide services via Telehealth.

http://www.lrc.state.ky.us/kar/907/003/170.htm

Can case managers no longer provide supervision to other case managers?
The qualifications for case management supervisors will be spelled out in the regulations.

Can we provide more than one service in a day, for example, a client has group therapy, then individual and then Therapeutic Child Support?
Yes.

Can you please clarify the question about CM and the MSPG (billing)?
Prior to the recent Targeted Case Management (TCM) State Plan Amendment (SPA), certain qualified providers could provide TCM as a Medicaid reimbursable service under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Medicaid required a separate EPSDT number.

After Centers for Medicare and Medicaid Services (CMS) clarification last year, Medicaid determined we did not need a separate EPSDT number for the providers. If they qualified as a regular provider type, they could provide the services under the EPSDT benefit and bill under their regular provider number. All the services were prior authorized anyway.

Now that the TCM SPA has been approved, any qualified provider including MSPGs can provide TCM to children under the age of 21 even without the regulations in place as it is covered benefit, and under the EPSDT benefit the regulations do not have to be in place. For Medicaid, they just must meet the requirements under the new TCM SPA. They can bill for the services under their regular provider number. The MCOs can determine for themselves whether they require a prior authorization or not. Fee for service will still require a prior authorization.

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MCOs should be providing covered services for its members. TCM is a covered service. The MCO does not have to track TCM or EPSDT Special Services in any special way. Again, a data pull of the applicable codes for children under 21 should reflect the services.

Nurses who are not APRN's are not included in the provider listing. Licensed RN's with a Master's degree in psychiatric nursing have always been Medicaid eligible providers and are authorized to provide psychotherapy under the Nurse Practice Act. Why are they not included on the provider list either as an independent provider or one under supervision?
The Centers for Medicare and Medicaid Services (CMS) (who provides federal funding for Medicaid services and who had to approve the corresponding state plan amendment authorizing BHSO services and associated requirements) instructed us to not include nurses as authorized practitioners. Additionally, therecorrect is confusion as to the qualifications of a psychiatric nurse as the term is not defined in a Kentucky Revised Statute.

Are BHSO's able to provide medication management services?
Medication management is not a billable service in itself. It can be provided as a component of another service but there is no reimbursement for medication management. The Centers for Medicare and Medicaid Services (CMS) did not approve it as a separate, billable service nor provide federal funding for it.

If we are already enrolled as Medicaid provider, do we need to submit anything else once the Behavioral Health Service Organization license is received?
An enrollment application will need to be submitted in addition to the supporting documentation as referenced on the BHSO provider type summary.

Behavioral Health Services Organization (BHSO) & Multi-Specialist Provider Group (MSPG) Related Questions

What is the difference in BHSO and MSPG?
The BHSO requires licensure by OIG whereas the MSPG does not. There are some services which are only approved to be provided by a BHSO including mobile crisis, assertive community treatment, and residential substance use. Community support associates may only be employed by a BHSO.

What provider type is the BHSO and what provider type is the MSPG?
BHSO is provider type 03 and MSG is provider type 66.

If we are already a MSPG and our licensed staff are credentialed through that provider type, do we need to be credentialed under the BHSO? Also, what do we do with our MSPG number?
If individuals are already actively enrolled, a Map-347 form will need to be completed and attached to the BHSO Medicaid enrollment application. The MSPG provider number will terminate once the BHSO provider number is issued.

Provide insight for a residential treatment program that provides individual, group and family therapy and some substance abuse treatment. Which license (BHSO – MSPG) meets these services?
It will require the BHSO license and the AODE license if providing substance use disorder treatment.

Under the MSPG can providers provide services to higher level clients, such as clients that have dual diagnosis?
Yes

Is Therapeutic Child Support (TCS) the main benefit in becoming a BHSO in addition to the MSPG?
Therapeutic Child Support (TCS) is an IMPACT Plus service and is not included as a service in the State Plan. After 9/30/14, this service will no longer be provided. Comprehensive Community Supports is the "TCS-like" service that is available in the state plan for mental health disorders. Community Support Associates may only be employed by a licensed organization so this is a benefit of BHSO licensure. There are other reasons that an organization may choose to become a BHSO. Each organization should make this decision based on what is best for their business model.

Can residential treatment be provided, not outpatient, for dual diagnosis under MSPG?
No, residential services may not be provided by a MSPG.

Can individual, family, collateral therapy and case management be provided under an MSPG?
Yes

Medication management is not allowed as a stand-alone service under the MSPG designation, correct? What if the psychiatric provider is billing for therapy and/or assessment, during which medication management occurs?
Medication management may be provided as a component of another service but it cannot be billed separately as the Centers for Medicare and Medicaid Services (CMS) did not approve it (nor provide federal funds to pay for it) as a stand-alone service.

Who would provide supervision to the Certified Alcohol and Drug Counselor's, under the BSHO?
Any independently licensed clinician that is enrolled in Medicaid and is employed by the same BHSO. Note that the supervisory relationship cannot violate the supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.

Will six months of services be pre-authorized under the BHSO rather than 3 months under the MSPG?
Prior authorization timeframes are determined by the individual Managed Care Organizations (MCO).

Targeted Case Management (TCM) Related Questions

Until the regulations for Targeted Case Management (TCM) are filed, we can continue to employ BA level TCM's who are able to provide services under our MSPG, correct?

Prior to the recent Targeted Case Management (TCM) State Plan Amendment (SPA), certain qualified providers could provide TCM as a Medicaid reimbursable service under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Medicaid required a separate EPSDT number.

After the Centers for Medicare and Medicaid Services (CMS) clarification last year, Medicaid determined we did not need a separate EPSDT number for the providers. If they qualified as a regular provider type, they could provide the services under the EPSDT benefit and bill under their regular provider number. All the services were prior authorized anyway.

Now that the TCM SPA has been approved, any qualified provider including MSPGs can provide TCM to children under the age of 21 even without the regulations in place as it is covered benefit, and under the EPSDT benefit the regulations do not have to be in place. For Medicaid, they just must meet the requirements under the new TCM SPA. They can bill for the services under their regular provider number. The MCOs can determine for themselves whether they require a prior authorization or not. Fee for service will still require a prior authorization.

Once the regulations are in place, then any qualified provider can provide TCM to the entire Medicaid population regardless of age so long as they meet the requirements under the regulations.

The face of EPSDT Special Services (and the way we think of it) along with the face of Medicaid has changed and continues to evolve. EPSDT Special Services will continue to shrink since most of the services are covered under the state plan. EPSDT Special Services will be limited to only those services NOT covered under the state plan, or for which we need some type of special arrangement. If a covered state plan service has a limitation, then the medically necessary service can be prior authorized to exceed the limit for any child under 21 under the EPSDT benefit through the provider's regular provider number.

To track these services, Medicaid would do a data pull with the T2023 code for members under 21. It is my understanding there is some concern for how to track the Impact Plus children assigned to an MCO. All the MCO would have to do is pull the data for T2023 for children under 21 and then bump it against the list of current Impact plus members assigned to them.

MCOs should be providing covered services for its members. TCM is a covered service. The MCO does not have to track TCM or EPSDT Special Services in any special way. Again, a data pull of the applicable codes for children under 21 should reflect the services.

Provide clarification on where BA level TCM services need to be - under MSPG, approved providers are licensed professionals and provisionally licensed under clinical supervision. So MSPG's cannot employ BA level professionals, correct? So if a BA level TCM wants to provide services, they would need to be employed by a BHSO?

Prior to the recent Targeted Case Management (TCM) State Plan Amendment (SPA), certain qualified providers could provide TCM as a Medicaid reimbursable service under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Medicaid required a separate EPSDT number.

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Do we need to be a BHSO to provide Impact Plus like services such as Therapeutic Child Support (TCS), Targeted Case Management (TCM), Parent to Parent or can we provide those services with the MSG?
TCS and Parent to Parent are IMPACT Plus services and may not be provided after 9/30. Comprehensive Community Support services can be provided by an MSPG but Community Support Associates can only be employed by a licensed organization. TCM can be provided by an MSPG (see explanation above) as can Family Peer Support.

Can we please get some clarification again around TCM in the MSPG setting? That's for licensed individuals only? So if a BA level TCM wants to provide TCM services, which would need to go through a BHSO, correct?
Prior to the recent TCM SPA, certain qualified providers could provide TCM as a Medicaid reimbursable service under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Medicaid required a separate EPSDT number.

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When do you expect the TCM regulations will be filed with the Legislative Research Commission?
DMS continues to develop them in collaboration with DBHDID but cannot give a date at this moment.

We are currently seeing adult Medicaid clients who desperately need case management; do we have to wait for the TCM emergency regulation to be filed in order to provide TCM to those clients?
Yes, as DMS/Medicaid cannot reimburse for the services until the regulations are officially in effect.

Once KIP goes away, would TCM be provided under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) until the regulation is filed?
Prior to the recent TCM SPA, certain qualified providers could provide TCM as a Medicaid reimbursable service under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Medicaid required a separate EPSDT number.

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So, does that mean, effective August 1st, TCM is no longer a service we can provide for new members?
No, please see above

Can we continue to provide TCM services by Bachelor's level staff for current Impact Plus clients until 9/30/14? Since we cannot bill for services, is there going to be an extension to this 9/30 deadline?
There will not be an extension, but TCM service can be provided. See above explanation.

It seems like the number of questions related to the topic of TCM that folks are confused. Can you help the IP providers how TCM is going to look between now and October?
IMPACT Plus Case Management will be provided in exactly the same way between now and October 2014.

General Questions

Is there any deemed status or reciprocal recognition of national accreditation such as Commission on Accreditation of Rehabilitation for the BHSO?
No

Is every provider required to be credentialed under the BHSO? What about the staff under supervision?
No. The BHSO must be credentialed as must all of the independently licensed individuals.

What are the differences between Impact Plus Services and services for which a Behavioral Health Service Organization is required?
IMPACT Plus services are not provided within a BHSO.

Is the date going to be extended for new case management eligibilities when we do not have a mechanism to bill?
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